www.marylandcancerplan.org
Prostate Cancer Committee Meeting #1
May 9, 2002, 4-6pm
Johns Hopkins Bunting-Blaustein Bldg, Rm 1M06
MINUTES

➪**Introductions and Committee Membership (Donna Cox)**

•Committee members were asked to introduce themselves by name and organization. Each was also asked to comment on their motivation for participating on this committee.

➪**Background on Comprehensive Cancer Control (Kate Shockley/Robert Villanueva)**

•The Maryland Council on Cancer Control and key administrators within the DHMH/ Center for Surveillance and Cancer Control are charged with the oversight for this grant. An organizational chart for the planning process is included in the Committee Materials binder.

•Maryland developed cancer plans in 1991 and 1996. The 1996 plan included a chapter on prostate cancer which can be found in the Committee Materials binder. Also included in the binder is a draft outline for the 2003 Maryland Cancer Plan.

•Many states have existing cancer plans, and the prostate cancer sections of the Michigan, North Carolina, and Massachusetts plans can be found in the Committee Materials binder.

•A committee roster was passed around. Members were asked to make corrections and add credentials. Member information, including name and organization, will be listed on the website and in the final published cancer plan. Members were given an opportunity to raise objections or ask questions. No members objected to this display of their information.

•In June 2001, an RFA was released by the CDC and states were encouraged to apply for funds to either write or implement a Comprehensive Cancer Control plan in their state. Maryland applied for funds to update the existing cancer plan.

•In September of 2001, the Maryland DHMH was awarded a 2-year cooperative agreement to update the 1996 Maryland Cancer Plan.

• Currently there are 13 states funded to implement their Comprehensive Cancer Control plans. In addition, there are 7 states funded under the Planning phase and scheduled to update or rewrite their cancer plans.

•One requirement of the grant is that an evaluation component must be incorporated into the planning process. The CIPP Evaluation Model was chosen during the writing of the grant proposal. CIPP is an acronym for **C**ontent, **I**nput, **P**rocess and **P**roduct. The CIPP Model is a process/satisfaction-oriented evaluation tool designed to evolve as we move through the various phases of developing a new cancer plan for Maryland.

•At the end of **each** meeting, committee members will be asked to complete a one-page evaluation and turn it in to the staff liaison attending your session. The comments will be compiled and shared with you at the **beginning** of each subsequent meeting. Changes will be made in the meeting process as may be warranted based on the group comments.

•The evaluation form is also available online for those not able to complete it at the end of the meeting (http://www.marylandcancerplan.org/evaluation.html).

➪**Presentation of Data (Bill Nelson)**

•Slides available in the Committee Materials binder.

Summary of key points and questions throughout the discussion of the data:

•Autopsy studies have shown that latent prostate cancer is found in almost 90% of men that die of other causes.

•Incidence rates increased dramatically when screening practices were first put into use. Incidence then leveled off around 1995. Overall, incidence is much higher in African-American men in Maryland and the U.S. than in white men.

- The major risk factors for prostate cancer include being male and increasing age.
- Mortality rates are falling in Maryland and the U.S. Several possibilities exist to explain this trend, including increased screening and early detection and/or better treatment methods.
- Mortality is much higher for African-Americans. Again, several possibilities exist to explain this trend.
    - Differences in androgen receptors may intrinsically alter the disease in African-American men
    - White men may be more willing to accept aggressive therapy
    - Differences in SES may lead to disparities in access to care, diet/lifestyle
- More men are diagnosed at the local/regional stage of cancer, which is driven by screening efforts. In Maryland and the U.S., whites tend to be diagnosed at earlier stages than blacks.
- Questions regarding the number of unstaged cases. A software problem at the University of MD may be contributing to cases being termed “unstaged” when a diagnosis really exists. Also, much prostate cancer is diagnosed in physicians’ offices, and the records don’t get to the hospitals where the registries are.
- The rates for 5-year survival are increasing which could be due to improved treatments.
- In general, clinical trials show a large percentage of African-American men as participants. However, many may not be eligible candidates because of a high incidence of co-morbid illness such as diabetes and high blood pressure.
- Screening numbers have increased, with much more PSA testing being done now. However, a significant percentage of screening tests find cancers that will not progress and may not require treatment.
- A number of environmental and lifestyle factors appear to be important regarding prostate cancer risk and prevention.
    - Low incidence among Asian men as evidence of diet factor
    - Electrophiles and antioxidants (i.e. selenium, lycopene may be protective factors)
    - Inflammation may increase risk
    - Animal fat (especially cooked to high temperatures) consumption may increase risk
    - STD infection may increase risk
    - Calcium intake may increase risk
    - Sun exposure may <u>decrease</u>? risk
- Member suggestion to review options for HIV positive patients diagnosed with prostate cancer.
- Member suggestion to review Ann Klassen’s data, perhaps at the next meeting.
- Announcement of presentation by H. Ballantine Carter, MD on Thursday, May 16 at 2pm “Prostate Cancer Screening: What we know and what we don't know" at JHSPH, Room W7023.

Next Meeting – May 28, 2002, 4-6pm